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SURGEON'S CIRCULAR LETTER

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INFORMATION OF GENERAL INTEREST TO MEDICAL DEPARTMENT PERSONNEL

To keep Medical Department personnel informed on personnel developments of interest, the Personnel Division, Surgeon General's Office, Washington, D.C., has instituted a "Personnel Newsletter" to be issued periodically. In order that pertinent information contained therein may be disseminated with the least possible delay to all Medical Department personnel in the Far East Command, the following extracts are published herein:

ARMY NURSE CORPS OPPORTUNITIES:

The Army Nurse Corps' greatest need at present is for nurse anesthetists and obstetrical and pediatric nurses. Attention is called to the many graduate educational programs now available to nurses on extended active duty. Among these are the accredited courses in anesthesiology which lead to examination and certification by the American Association of Nurse Anesthetists.

PLEASE REPORT CHANGES IN NUMBER OF DEPENDENTS:

To avoid making assignments which are inappropriate, the Personnel Division, SGO, must know every officer's current dependent status. Officers are urged to report at once, through channels, any change in the number of dependents.

PROMOTIONS:

Orders announcing the temporary promotion of officers selected by the board convened in February, 1949, and permanent and temporary promotion selections made by the March, 1950, board, are expected before the end of the current fiscal year, 1 July. Promotions include:

Lt. Colonel to Colonel.....	MC, DC, VC, and MSC
Major to Lt. Colonel.....	MC, DC, VC, and MSC
Capt to Major.....	DC, VC, and MSC
1st Lt to Capt.....	MSC

Officers selected for temporary promotion in February, 1949, were notified of their selection by letter in May, 1949.

A board was convened late in March, 1950 to select first lieutenants of the Medical, Dental, and Veterinary Corps, who complete one year of active commissioned service by 1 July 1950, and who have at least six months service remaining prior to completion of their tour of duty, for temporary promotion to the grade of captain. The rendition of DA AGO Form 78 is not required unless requested in specific instances, as selections will be made on the basis of records available to the Surgeon General's Office. Promotion of officers selected will be announced from time to time as they complete their year's service.

EFFECTIVE DATES OF PROMOTION:

It is not known when orders will be issued announcing the promotion to permanent and temporary grades Colonel, Lt. Colonel, Major and Captain of the MSC, ANC and WMSC officers selected by the boards convened in February, 1949, September, 1949, and March, 1950. It is believed these promotions will be announced in monthly increments, with all announcements being accomplished prior to 1 July 1950.

PUBLICATION OF PROMOTION LISTS:

According to present information, promotion lists are to be included in the Army Register published in 1950.

WOMEN DOCTORS AND SPECIALISTS:

Legislation to provide for appointment of qualified women doctors and other women specialists in each of the pertinent male corps of the Medical Department, both Regular Army and Reserve, on the same basis as male officers (H.R. 4384) was passed by the House and is now pending in the Senate Armed Services Committee.

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NO. 5

1 May 1950

PART I

ADMINISTRATIVE

<u>SUBJECT</u>	<u>SECTION</u>	<u>PAGE</u>
Organization of the Medical Section.	I	1
Extracts from Talks Presented at 1950 FEC Surgeons' Conference	II	1
"Eighth Army Medical Service"		1
"Medical Department - Fleet Activities"		2
"Navy Medical Situation in the Marianas".		2
"Medical Service and Medical Problems of the Far East Air Forces"		4
"Medical Service on Okinawa".		4
"Marianas-Bonins Command Medical Service"		4
"Medical Service and Medical Problems of the Fifth Air Force"		5
"Getting Going on Okinawa Gunta".		6
"Medical Field Work - 406th Medical General Laboratory"		7
"The Medical Service, Headquarters and Service Group"		8
"The Medical Service and Medical Problems of the Far East Air Materiel Command"		8
"Repairs and Utilities Activities as They Pertain to Hospitals"		9
"The Role of Air Evacuation in Military Medicine"		11
"U. S. Naval Medical Facilities, Philippines"		12
Recent Department of the Army and FEC Publications	III	13
Index.	Inside Back Cover	

I. Organization of the Medical Section

Arrival in the Medical Section, GHQ, FEC: Colonel F. W. Pruitt, MC, formerly Chief, Medical Service, Tokyo General Hospital, has been assigned to duty as Medical Consultant to the Chief Surgeon, Far East Command.

Departure from Medical Section, GHQ, FEC: Lt. Colonel Allen J. Blake, MSC, Chief, Plans and Operations, has completed his overseas tour of duty and returned to the ZI for reassignment.

II. Extracts from Talks Presented at 1950 FEC Surgeons' Conference

As a matter of interest from both the technical and non-technical aspects of medical service and problems, the following extracts from papers presented by visiting conferees at the 1950 Far East Command Surgeons' Conference are published:

EIGHTH ARMY MEDICAL SERVICE

Col C. E. Dovell, MC, Surgeon, Eighth Army



.....Non-standard supplies in Eighth Army are purchased by means of expenditures of credits allocated to Eighth Army at the San Francisco Medical Depot. During fiscal year 1950, Eighth Army was allotted about \$60,000. Our expenditures will consume the amount allotted. With such funds, drugs not listed in the catalog are purchased; some because they are "specifics," and others for many justifiable reasons. New drugs are constantly being developed, and these are purchased to keep abreast of current medical requirements or perhaps on the advice of a consultant.

Habitually, non-standard items are not carried in stock. Due to the limitation of funds, we do not routinely purchase large amounts of any such drugs or equipment. In order to explain the apparent delay in the receipt of NS supplies and equipment which are requisitioned from time to time, we would like to point out that order and shipping time is 120 days. That means that it would take 120 days from the

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time that a requisition is placed in the mail, received at the port, sent to a depot, depot to the purchaser, purchaser to depot, depot to port, port to a ship, ship to the depot here and received. When an emergency is apparent, airlift or priority water shipment will reduce shipping time by as much as three months. While on the subject of non-standard supplies, we would like to point out that Army regulations require that requests for non-standard supplies be adequately justified. In this connection it is noted that resistance is offered, not from supplying agencies but from professional personnel who feel affronted when asked to explain why a non-standard item is required and why a standard item will not suffice. The feeling appears to be "well, I'm going to use the drug or material to treat patients in the best manner that I know." While such attitude is highly commendable, it does not help the supplying agency since the ordinary layman does not know why a drug is used and what characteristics indicate its use. We also view the matter with an eye toward economy. When the objective desired by using a particular item is ascertained, we quickly screen our available stocks which, in some cases, result in a similar item being available. Direct contact with the requesting agency and the user usually resolves problems of this nature. If the request is processed at the San Francisco Port and the specific item cannot be procured, a substitute item that has the same characteristics as the drug requested is frequently furnished.....

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MEDICAL DEPARTMENT - FLEET ACTIVITIES

Capt J. B. Butler, MC (USN), Senior Medical Officer
U. S. Naval Fleet Activities, Far East



.....Now to give you a brief outline of the activities of the Navy Medical organization in this command.

The Navy has a rather small set up in the Far East Command in point of personnel. There is a fluctuating total, depending upon the number of ships operating here at any one time. Of the personnel that are present a great many are in small units and contingents operating at times through all the coastal waters of Japan and a number of outlying islands - many of the smaller units operate in remote places quite without immediate presence of doctors and with hospital corps personnel administering to their medical needs. We have all sorts of problems in such a set up, as you might imagine. All ships sooner or later, and at varying intervals report for overhaul, servicing, and recreation at Fleet Activities, Yokosuka, and at that base they are provided with full medical care, hospitalization, provision of medical supplies and logistic support, inoculations, and instruction in preventive medicine measures as required for their particular needs.

Occasionally a group of Mine sweeps will operate in a remote area such as the Soya Strait north of Hokkaido, three or four hundred miles away from any Armed service hospitals and for a fairly extended period. When such a group, with total personnel aggregating several hundred men, go on such a tour of duty, we are called upon as we will be in April to send one of our medical officers along for a month or so. We always rest a lot easier when vessels of this type are operating in areas not too remote from Army or Air Force medical facilities.

Our other shore based activities are minor from the standpoint of numbers of personnel. These include Sasebo Naval Base, Radio Station Totsuka, the air facility at Oppama and our activities here at Tokyo. For the most part, their first aid and minor medical needs are met by hospital corpsmen; patients may be transferred to the medical facilities at Yokosuka for hospitalization when able to travel or they may, if they prefer, as in most cases, be sent to the Army or Air Force dispensaries or hospitals in their immediate locality.

In addition to the purely Naval activities accomplished at our base at Yokosuka, the Commander of this facility exercises military or occupational jurisdiction over a Japanese urban area consisting of several cities totalling about 250,000 people designated as the "Naval zone of responsibility" or jurisdiction.....

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NAVY MEDICAL SITUATION IN THE MARIANAS

Captain Lawrence E. Bach, MC (USN), Staff Commander Naval Forces Marianas



.....Trust Territory of the Pacific Islands: The Trust Territory of the Pacific Islands covers an area of some three million square miles in the western Pacific Ocean north of the equator. The territory contains 96 distinct island units with a combined land area of about 687 square miles. The territory comprises those islands formerly held by Japan under mandate from the League of Nations and consists of those Micronesian island groups known as the Marshalls, the Carolines, and the Marianas (with the

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exception of Guam). The islands forming the Trust Territory stretch from about latitude 1 degree to 20 degrees north and from longitude 130 degrees to 170 degrees east. The distance from Tobi Island in the extreme west of the Carolines to Mili Island in the extreme east of the Marshalls is about 2,400 nautical miles, 2,727 statute miles.

The islands may be classified broadly as either "high" volcanic or "low" coral islands. The volcanic islands, which lie predominately in the western portion of the Trust Territory, represent the exposed peaks of a submerged volcanic range which stretches from Japan southward through the Bonin Islands, the Marianas, Yap and the Palau Islands to New Guinea. With the exception of the volcanic outcropping of Truk, Ponape, and Kusaie all the islands to the east of this volcanic range are of coral formation, mostly in the form of atolls.

The climate of the Trust Territory is, in general, tropical and rainy with small seasonal changes. Throughout most of the area the mean annual temperature averages from about 75 degrees to 85 degree F. with a diurnal range of less than 10 degrees F.

Rainfall is heaviest in the belt between 1 degree 30' and 8 degrees 30' north latitude where the average annual rainfall is over 120 inches. On the "high" islands within this zone the precipitation is considerably greater, being augmented by aerographic rain. On the northern islands and atolls of the Marshall group there is a pronounced dry season during which water scarcity becomes a problem.

The Trust Territory is divided for administrative purposes into the following five administrative districts: Saipan, Palau, Truk, Ponape and Marshall Islands. During the past year the former Yap district has been made a sub-division of the Palau district, and the former Kwajalein and Majuro districts have been consolidated into a single Marshall Islands district with headquarters at Majuro. The headquarters of the High Commissioner of the Trust Territory of the Pacific Islands are at Pearl Harbor in the Territory of Hawaii. Three-fifths of the population live on the six principal island units: Saipan, Yap, Truk, Ponape and the Palaus and Majuro. The other two-fifths are widely scattered and many of the isolated islands and atolls are inhabited by only a few dozen people. Many more are entirely uninhabited. There are no incorporated cities or towns in the Trust Territory. With the exception of several well-defined communities on Saipan, most of the people live in small settlements and farmsteads scattered over the individual islands and island groups.

The inhabitants of the trust Territory are broadly classed as Micronesian, i.e., people of the tiny islands. They are divided into a number of regional and local groupings which differ more or less in physical characteristics, language and customs. The Micronesian stock is characterized by medium stature, brown skin, and straight to wavy black hair. Certain Mongoloid features may be distinguished among the islanders of the west and central Carolines; Australoid characteristics are encountered in the southwest islands; while Polynesian types occur in the Marshalls. The Chamorros in the Marianas, although a racial blend, tend to resemble the people of the Philippine Islands and may be distinguished as a distinct ethnic group in contrast to other Micronesians.....

.....The USS WHIDBEY (AG-131), specially outfitted and staffed is assigned a full time mission of conducting a medical survey in the Trust Territory. The medical department consists of 2 medical officers, (one with special training in x-ray diagnosis of tuberculosis), one dental officer, one Medical Service Corps officer, (Entomologist), and 10 enlisted hospital corpsmen, (9 qualified technicians in x-ray and laboratory work).

The ship is equipped with complete laboratory, x-ray, photofluorographic and dental facilities. About 120 persons are processed each day. The survey includes a complete physical examination, chest x-ray, stool examination, blood serology (Kahn), dental examination, tuberculin test, tests for coccidiomycosis and histoplasmosis, plus any special laboratory work that may be indicated by findings in the examination. The diseases especially tabulated and searched for are: tuberculosis, pulmonary and extra pulmonary, yaws, intestinal infestations, filariasis and dental caries.

To date all inhabited islands in the western Carolines group including Yap, and all islands of the northern Marianas Islands, and about 2/3 of the Marshall Islands have been visited and processed. This represents about 22,000 people.

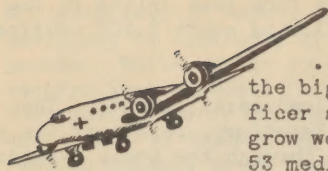
The following incidence of more common disease has been found: Tuberculosis, pulmonary, arrested and active - about 1.5% of total population; Yaws (as evidenced by positive blood serology) - 70 to 75%; Intestinal parasites - about 68%; Filariasis - about six cases to date; Eye conditions, conjunctivitis, pterygium, and cataracts are very common.

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MEDICAL SERVICE AND MEDICAL PROBLEMS OF THE FAR EAST AIR FORCES

Col R. J. Platt, MC, USAF, Surgeon, FEAF



.....At these conferences in the past, and this one will be no exception I'm sure, the biggest "gripe" has been in regard to personnel, and in particular the medical officer shortage. This shortage instead of improving as time goes on seems to steadily grow worse. During May, June and July of this year FEAF will be really hit hard. From 53 medical officers on duty with FEAF at the end of January 1950, we will be down to 28 by the end of April 1950, and to 21 by the end of May 1950. Headquarters, USAF, has been unable to promise much relief for this situation.

During the past year we have been barely able to keep our heads out of water with the number of medical officers we had, and now we are faced with what will be a desperate situation indeed.

Our dental situation is much brighter than the medical one. As of January 1950 we had 40 dental officers and 14 civilian dentists assigned. Of these 14 civilian dentists 11 were United States citizens, 2 were Filipinos and 1 a Japanese dentist. Five United States civilian dentists are on duty here in Japan, 2 United States civilian dentists and one Filipino dentist are on duty in the Philippines with the Thirtieth Air Force, 4 United States civilian dentists and one Filipino dentist are on duty on Okinawa with the Twentieth Air Force, and the Japanese dentist is on duty with the 1st Medical Squadron in Tokyo.....

Our veterinary officer situation is a rather tight one. We have in the entire command only six veterinary officers. Three of these are on duty at various bases in Japan and two are on duty in the Philippines. The 6th one arrived recently for duty on Okinawa.

We have no problems as far as the Medical Service Corps officers and the Nurse Corps officers are concerned. Our supply of these officers is very good.....

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MEDICAL SERVICE ON OKINAWA

Col James L. Snyder, MC, Surgeon, RYCOM



.....The native population of Okinawa is represented by a primitive people, occupying an inferior status in culture, intellect and scientific development, when compared to American standards. This indigenous population presents a unique problem to the Commanding General of the Ryukyus Command in that it is not capable, in any way, of providing any medical service or facilities which are even remotely acceptable to the American Occupation Forces. The Commanding General, because of this fact, cannot seek assistance from the local populace for medical care, but in turn, is often required to render medical assistance to the Okinawans through their Military Government establishments.....

Discussion:.....They have 120 native doctors for a native population of 550,000. Generally, they don't care much about laboratory confirmation but practice essentially clinical medicine. It is a difficult problem. Because of the complete destruction of houses, two or three families live in one house. Also because of this overcrowding, the tuberculosis rate has gone up tremendously. There is nothing indigenous on the island with which to build and until they get more material for construction and more doctors educated, general health has a gloomy future.

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MARIANAS-BONINS COMMAND MEDICAL SERVICE

Col L. N. Swanson, MC, Surgeon, MARBO



When hostilities ceased suddenly in the Pacific, materiel and supplies for the pending invasion of Japan were diverted to islands of this command for processing and storage pending ultimate disposition. The Marianas-Bonins Command consisted of the Army Garrison Forces and the Army Air Forces, and operations were taking place on Guam, Saipan, Tinian, as far north as Iwo Jima in the Bonin Islands Group, and as far south as Manus and Los Negros. The Navy resumed the administration of the civilian population here, a task which first commenced following the occupation of Guam after the Spanish-American War. The senior officer in the Army present for duty was in command of all Army and Air Force troops. Later, when the Air Force was established as a separate service, there resulted on this island three separate commands: Navy, Army Garrison Forces, and United States Air Force.

The mission of the Marianas-Bonins Command is briefly then, the responsibility for the roll-up

of all supplies and materiel which were intended to be used in the assault on Japan. Another mission is the logistical support of elements of the 20th Air Force remaining at Andersen Air Base on the northern end of Guam.

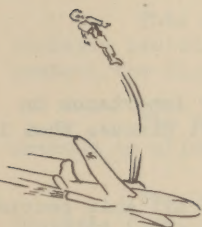
From the foregoing, the mission of the medical service here is, then, the disposal of excess depot stocks, the furnishing of medical supplies to the Air Forces, hospital care for Army and Air Force personnel, their dependents, DAC and DAFC personnel, operation of four dispensaries, operation of dental and veterinary services, supervision of sanitation and all activities in connection with the prevention of disease.....

Guam is, in spite of the humidity and oppressive heat, a healthy island. The sick rate for military personnel is consistently close to the lowest, if not one of the lowest in the Army. In spite of the favorable statistics, sanitary measures and the principles of preventive medicine must be maintained and rigidly adhered to. No small part of the favorable state of health is due to the sanitary engineers and insect and rodent control sections who daily seek and eradicate sources of disease. Dengue fever, recurrent malaria, and encephalitis have all been reported among the Filipino workers and the native population during 1949. Mosquitoes that can transmit these diseases are known to be in and near areas occupied by Army Ground Forces. Constant scientific warfare, however, against the types of mosquitoes potentially responsible for diseases keeps the mosquito population relatively harmless.....

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MEDICAL SERVICE AND MEDICAL PROBLEMS OF THE FIFTH AIR FORCE

Col Theodore C. Bedwell, Jr., MC, Surgeon



.....The most striking new field of aero-medical research and development introduced by jet aircraft is the problem of emergency escape from these high speed and high altitude aircraft. The pilot ejection seat which has been discussed for so long has now been released for operational use in certain of the newer aircraft such as the F-80C.

The possible disabling action of ultrasonic frequencies present in the sound fields generated by jet and rocket propelled aircraft has been much publicized. Present evidence does not indicate that airborne ultrasonic vibrations constitute a practical hazard to hearing or produce any specific effects on the nervous system or sense organs. In general, it is high intensities that are potentially hazardous, not high frequencies as such. Sounds about 120 db stimulate the sense of touch and may cause temporary and possibly permanent hearing loss. Levels about 140 db are painful to the ear and exposures to such levels without special protection should be avoided.

The vague subjective feelings of fatigue, annoyance, irritation, etc., induced by very intense sound or vibration may represent nature's first warning of the presence of a stress that is not yet severe enough to cause more objective manifestations. Additional research is indicated before definite conclusions can be drawn.

The high speeds of jet aircraft place a premium on quick reaction time. Pilots do many of the same things in flying jet aircraft that they do in flying other aircraft, but they have less time in which to carry out these activities. Instruments must be read more quickly and controls operated more rapidly. A moment's hesitation or a human error is much more serious than in slower aircraft.....

As a matter of refreshing our memories, the effects of oxygen-want may be roughly divided into three phases:

1. The first effect noted at altitudes between 10,000 and 15,000 feet is a feeling of well-being, elation, loss of inhibitions and lack of good judgment. Visual acuity at night is markedly reduced by hypoxia when flying above the equivalent of 8,000 feet while breathing air.
2. The second, and usually, a concomitant effect, is the development of fatigue and loss of efficiency which may lead without warning into the third phase, namely:
3. Loss of consciousness and death. A wide variation naturally exists in individual susceptibility to oxygen-want which may depend to a large measure on the physical condition of the crew member. Loss of consciousness rarely occurs below 15,000 feet. The average times at which unconsciousness may occur on failure of oxygen supply at various altitudes is tabulated below:

<u>Altitude</u>	<u>Average Time Required for Loss of Consciousness</u>
20,000 feet	15 minutes
25,000 feet	3 minutes

<u>Altitude</u>	<u>Average Time Required for Loss of Consciousness</u>
30,000 feet	1 minute
35,000 feet	45 seconds
40,000 feet	30 seconds
45,000 feet	20 seconds

Unconsciousness from hypoxia occurs without warning; the suddenness of its effects and lack of warning make it a thing which must be prevented rather than treated. Prevention requires thorough knowledge of the proper fit, use and maintenance of personal oxygen equipment.

From the above, it is apparent that the pilots' mental and physical condition have to be excellent if they are to operate their planes safely. It is the responsibility of the Flight Surgeon to maintain close observation of the pilots in order to detect any condition which would make them unfit to fly. If he finds pilots are unfit to fly, it is his responsibility to recommend to the Commander that the pilot be prohibited from flying until he has returned to normal. Abnormal behavior patterns or minor physical defects can often be corrected when discovered early and placed under proper treatment. If these conditions are allowed to go undetected, the pilot might endanger his own life, as well as the lives of others, in addition to causing damage to the aircraft.

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GETTING GOING ON OKINAWA GUNTA

Col Howard W. K. Zellhoefer, MC, Surgeon, 20th Air Force



.....Men, Money and Materiel - these are perhaps of more primary importance on Okinawa than in 95% of the remainder of the democratic world. We will discuss them in that order.

.....It has been my experience that medical personnel, as indeed all able people, are capable of sustained efforts far more than is required by the unionized 40 hour week, providing that ideals, inspirations and a general feeling of optimism are present in the air they breathe, in the food they eat and in their off duty activities..... In conformity with these beliefs much has been done with the 20th Air Force Medical Service personnel to keep their collective minds occupied. Officers and enlisted personnel have been encouraged to be leaders in all forms of extra-curricular activities available to them..... Opportunities are sought which will provide interesting temporary duty or detached service in commands located away from Okinawa. Negotiations are under way at present with the Surgeon of RYCOM to provide opportunities for Air Force medical personnel to work with Army medicos in the 34th General Hospital during afternoons and in emergencies where their services can be used. We expect this arrangement to be mutually profitable during the coming transition period when ASTP personnel will have departed for the ZI and additional medical personnel not yet arrived. All the ASTP personnel with the 20th Air Force have requested to extend their present duty assignments to as far into June as the law will permit. After they have departed we will have one Flight Surgeon and a civilian doctor working in each dispensary at Kadena and Naha..... The Dental officers present a different problem since it is more difficult to substitute an airman's services for a trained dentist..... However, the dental personnel at Kadena Air Base worked double shifts during the day and early evening hours for several months last autumn and are willing to do it again if necessity demands. New construction and repairs for the two dental clinics and dispensaries on Okinawa have so much improved the facilities during the past three months that the new ease of accomplishing dental and medical therapy makes up in a large measure for the decrease in number of practicing professional personnel.....

Money! It seems a shame to spend one dollar in other places where it receives so little when it can be spent in Okinawa to get so much. We are grateful for the 24 million dollars allocated to the 20th Air Force on Okinawa for the general improvement of existing facilities and the construction of new buildings. In my opinion, that amount of money could not do more anywhere to aid the military defense of the United States than on Okinawa with the 20th Air Force. The construction program is already underway. With each inch rise in the height of the buildings under construction there is a proportional rise in the morale of every individual on Okinawa - military, civilian and native..... \$665,000 of non-appropriated funds will be expended to build three new service clubs, two theaters, two libraries and two gymnasiums. Swimming pools, hobby shops and properly equipped athletic fields are now more than figments of the imagination. Money and Materiel! These two are as inseparable for Okinawa's progress as the Siamese twins, without one the other is doomed.....

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MEDICAL FIELD WORK - 406TH MEDICAL GENERAL LABORATORY

Lt Col R. L. Hullinghorst, MC, CO, 406th Med Gen Lab



..... Accomplishments in 1949: Review of the routine work performed would be of little value at this time. It should be mentioned, however, that this particular phase of activities has continuously increased since 1946 and with the closing of the 3d Medical General Laboratory in June 1949 additional responsibilities were added for the performance of laboratory support to PHILAIRCOM, RYCOM and MARBO. With establishment of unified medical care on Guam an offer of cooperation was extended to the Navy Medical Center of that area. Medical units at Yokosuka have availed themselves of certain of our services in the past.

Specific projects engaged in during 1949 can be briefly reviewed. The Section of Medical Zoology continuing its epidemiological studies in native populations completed surveys of Okinawa and the Islands of Shikoku and Hokkaido. With the exception of two or three additional sites in Japan we now have first hand knowledge of the distribution and prevalence of each type of intestinal parasite in Japan, Korea and Okinawa. For your information, roughly 90% of all natives in these three areas harbor some intestinal parasite of known pathogenicity. In Japan and Korea the prime offender is *Ascaris*. In Okinawa it is hookworm. It is somewhat surprising that despite the recognizable pollution of water, *Endamoeba histolytica* appears to be of little importance with the exception of a very few limited areas. This project also has served to outline endemic areas of schistosomiasis and paragonimiasis.

This same section has also continued long-term investigations on methods of control of schistosomiasis including protective clothing, protective ointments and use of molluscicides in an effort to control the disease by elimination of the snail host.

The Bacteriology Section has developed what appears to be very satisfactory holding media and methods to allow shipment of suspected gonorrheal discharges and stool specimens for pathogenic bacteria.

The Chemistry Section continues to establish additional laboratory diagnostic procedures when requests from hospitals warrant such examinations. Samples of oxygen procured locally for Medical Department use are now routinely tested for purity. A broad evaluation of stocks of halazone tablets has revealed marked deterioration of most of the theater stocks. Certain specific lots have been found to retain approximately 50% of their required chlorine and such information has permitted the Quartermaster agencies to distribute such stocks only with directions for use in twice the normally prescribed amounts.

..... The serologic confirmation of Japanese B encephalitis has now become completely routine, thus allowing more satisfactory evaluation of the prevalence of the disease and of unapparent infections. A four year project has been completed on approximately 60,000 Japanese school children to determine the evaluation of Japanese B encephalitis vaccine. Despite the long term nature and the large size of the group studied, the absence of the disease in epidemic proportions in the study area still warrants only cautious approval of the preventive value of the vaccine. Based on the small number of cases among the 60,000 children it can only be said that the vaccine offers "some protection."

An epidemic affecting some 5,000 Koreans this past summer was established as due to Japanese B virus. This is the first American or Japanese knowledge of the disease in native Koreans.

Continuing epidemiological alertness has also allowed the virus section to give early confirmation of the appearance of influenza "B" in the Japanese population on the island of Shikoku in December and later its appearance in military personnel in the Tokyo-Yokohama area. In Korea influenza "A" or "A'" has been established. A watchful eye is still being kept for the appearance of influenza "A" known to be present this season in the United States.

A previously unsuspected area of Japan utilized by the Army for annual maneuvers was discovered to be an endemic focus of scrub typhus in 1948. A continuing check throughout the past year has failed to reveal the recurrence of clinical or subclinical infections in the units utilizing this area and lends some support to the effectiveness of the miticidal impregnation of clothing and other methods of control employed.

With the appearance of epidemic typhus in the Japanese an opportunity was offered for the evaluation of aureomycin and chloromycetin in this condition. To judge from the literature this will be the first such opportunity for a clinical evaluation of the former drug. This study is in progress at the present.....

..... With the gradual increase to something close to our authorized officer strength we hope

to continue more frequent visits to the laboratories of your commands in order to improve liaison and to offer technical advice on specific subjects. Should the outbreak of disease in any of your commands overload existing laboratory services or warrant amplified epidemiologic investigation by laboratory means, please remember that the 406th Laboratory is available for that purpose and will appreciate the opportunity for any help which we might give.

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THE MEDICAL SERVICE, HEADQUARTERS AND SERVICE GROUP

Lt Col W. S. Smith, MC, Surgeon, Hqs and Sv Gp



The Medical Service of Headquarters and Service Group consists of outpatient care to occupation personnel in the Tokyo area. This service is furnished through the Tokyo Dispensary and branches thereof which function directly under the jurisdiction of the Surgeon, Headquarters and Service Group, better known as the Group Surgeon, who serves in a dual capacity, that of Group Surgeon and of Commanding Officer of the Tokyo Dispensary.....

The Group Surgeon acts as the advisor to the Commanding General, Headquarters and Service Group, on all medical matters incident to the health of the Command, which includes all health conditions within the Tokyo area. Policies set forth must be closely coordinated with Headquarters, Far East Command and Headquarters, Eighth Army. Also, a close working relationship must exist with the Eighth Army hospitals located in the Tokyo area as well as with Public Health and Welfare Section, SCAP.....

The Tokyo Dispensary, a recent designation obtained through the consolidation of two (2) General Type Dispensaries, the 385th and 386th with the 8228th Medical Service Detachment, consists of a large general type dispensary and seven branches, two of which are battalion dispensaries manned by personnel other than the Tokyo Dispensary personnel but remain under the technical supervision of the Group Surgeon.....

The Tokyo Dispensary and Branches thereof furnish first echelon medical service to all Occupation personnel, their dependents, correspondents, members of foreign missions, and all personnel affiliated or accredited with SCAP who are located in the Greater Tokyo Area. In addition, emergency medical treatment is rendered personnel regardless of their status. The population served numbers in the vicinity of 30,000.....

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THE MEDICAL SERVICE AND MEDICAL PROBLEMS OF THE
FAR EAST AIR MATERIEL COMMAND

Lt Col F. L. Foster, MC, Surgeon, FEAMCOM



The Far East Air Materiel Command, APO 323, is located 24 miles west of Tokyo and five miles west of Fuchu, Japan, at Tachikawa, Japan. This location was the "Wright Field" of Japan during the war. FEAMCOM is the supply and maintenance center for all Far East Air Force units' aircraft. It also maintains an industrial plant that manufactures motor vehicle and aircraft parts, in which approximately 6,000 Japanese are employed.

Although FEAMCOM is considered a major command for medical operations, it is essentially the same as any large base operation. The senior medical officer performs the combined duties of Staff Surgeon, FEAMCOM Headquarters, Base Surgeon, Commanding Officer of the 13th Medical Group, Depot and Commanding Officer of the 376th Station Hospital; the scope of operations does not make this as complicated as it sounds.

In July of 1949 the Headquarters of FEAMCOM, then located in Fuchu, Japan, moved to the present location to combine with Japan Air Materiel Command to form the Far East Air Materiel Command. At this time the 13th Medical Group, Depot was activated and the Dispensary designated as the 13th Medical Group Dispensary; this changed our medical operations very little. The 376th Station Hospital was then attached to the 13th Medical Group, Depot for operational control.

FEAMCOM consists of the Headquarters and Base of FEAMCOM and sub-bases of Area "A" at Showa and Area "B" at Fuchu. Kisarazu is also a sub-base situated about 65 miles southeast of Tachikawa. In October 1949, FEAMCOM assumed command of all activities on Iwo Jima.

In addition to all FEAMCOM units, medical and hospital service is provided for Tachikawa Air

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Base, a Fifth Air Force Base, which operates a dispensary and has two medical officers assigned. Army units in the vicinity provided medical care and hospitalization are: 8002d Hydro-ponic Farm, Depot, 587th Ordnance Service Company, 43d Engineer Construction Bn, and 77th Engineer Construction Bn; all of these are small units.

The 13th Medical Group Dispensary is located right in the 376th Station Hospital, and although administratively it functions entirely separately from the hospital, professionally it is operated as part of the hospital. All medical officers hold sick call and dispensary officers are rotated daily in the same manner as the Medical Officer of the Day. In this way no one gets full time dispensary duty.

The 376th Station Hospital is an Eighth Army hospital attached to FEAMCOM for operational control; it operates as a 200-bed hospital with expansion facilities to 350 if necessary. By combining the duties of Air Force personnel and Army personnel and operating professionally as one organization and administratively as two, there have been no difficulties at all. Full cooperation and help by FEAF and Eighth Army Surgeons have made this ordinarily complicated organization a very simple one.

The sick call at the nearby sub-bases and Army units is screened by a Medical Administrative Officer and patients who require further care or examination are transported to the hospital. This has worked very well for one year and not a single complication has resulted from this procedure.

A medical officer had been flown twice weekly to Kisarazu sub-base until January 1950, at which time a construction project was started at that base and it was deemed necessary to keep a doctor there full time. Iwo Jima, due to its extreme isolation, naturally requires a full time doctor. The duties at Kisarazu and Iwo Jima are rotated every month so that the monotony can be broken as much as possible.

The 376th Station Hospital operates the same as any station hospital of its size, including an obstetrical service. There have been no supply problems other than occasional delay in obtaining certain drugs, such as pyribenzamine. Close proximity to Tokyo General Hospital and the 361st Station Hospital has solved our evacuation problems.....

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REPAIRS AND UTILITIES ACTIVITIES AS THEY PERTAIN TO HOSPITALS

Lt Col L. C. Fairbank, Jr., Engineer Section, GHQ, FEC



..... I have been asked to speak to you on the subject of Repairs and Utilities Activities as they pertain to hospitals..... This morning I hope not to dwell on old complaints too much but rather, accepting them in their present status as existing facts, to outline specifically what can be done within the means available, to improve repairs and utilities activities in your hospitals.....

Repairs and utilities activities, as they pertain to hospitals, are not far different from those that apply to other Army occupied facilities. The mission, briefly, without quoting several pages of Army Regulations, is to provide a service, and the means with which this service is furnished consist of money, men and materials.....

Now to get down to your problem, repairs and utilities in hospitals. The majority of the hospitals are dependent for repairs and utilities support upon the Post Engineer of the installation in which the hospital is located, or possibly the hospital is a separate installation in itself and has its own post engineer. In any event, it is a post engineer who is charged with the responsibility of providing repairs and utilities services. Due to the varied types of services required; the essential nature of the facilities; and often the size of the hospital itself, it is most desirable that a cellular utilities organization be established within the hospital itself to provide repairs and utilities support for the hospital. Such arrangements have been made at the Philippine Scout Hospital, the 34th General Hospital on Okinawa, and the Tokyo General Hospital here in Japan, to mention only a few examples. Oftentimes, the post engineer is unable to provide an officer to head such an organization, and in such instances, it is not uncommon for the Surgeon commanding the hospital to provide an Administrative Officer for this purpose. This has been done at the 361st Station Hospital here in Tokyo and at the 161st Station Hospital in Sapporo.

With the limited means available at post level, the post engineer's problem is basically somewhat akin to that confronting the Surgeon with no doctors, and about all he can actually accomplish is to help others help themselves. Accordingly, the degree of success of the repairs and utilities program in hospitals is dependent not as much upon the post engineer, or the maintenance officer serving the hospital, as upon the support given him and the attention given this activity by the surgeon in command.

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Unfortunately, there is nothing written in our various Technical Manuals, Special Regulations, or Army Regulations elaborating upon and spelling out in detail the relationship that should exist between a post engineer and the post or installation commander to insure a satisfactory performance of the repairs and utilities services. Too frequently each is so involved in a myriad of details peculiar to his own work that he fails to recognize the possibilities of aiding the other to the mutual benefit of all concerned.

I trust that I will appear not presumptuous in offering suggestions as to how the commanding officer of a hospital might perform certain duties, but I sincerely believe, based upon observations in the field, that much can be done to improve and better the repairs and utilities activities at your hospitals by the mere observance of a few simple, basic fundamentals. In this light, it is hoped that my comments are not mistaken as criticism nor that they imply that post engineers or maintenance officers are beyond reproach.

Repairs and utilities is a command responsibility and as such requires the attention of all commanders; however, too often command attention consists of the issuance of an order to do such and such and have it completed within 24 hours. Of course, a commander has his prerogatives, but at the same time, he has an engineer, and in view of the critical engineer situation as regards funds, personnel and supplies, it would well behoove him to consult and at least listen to the recommendations of his engineer. If we were to total, in dollars and man hours, the amount of engineer effort expended in this manner, I dare say we would be somewhat amazed at the resulting figure, particularly when we consider the amount involved as a result of essential items neglected while performing such unprogrammed work.

As a Staff Officer, the post engineer or maintenance officer, should enjoy the confidence, not only of the Commanding Officer, but also the other members of the staff as well. Particularly is this true at those installations in which the majority of officers are of a single branch of service. This feeling of belonging will do much to create a sense of loyalty on the one hand, and to solicit the interest and assistance of all personnel on the other. At one medical installation, in which such relations existed, the nurses spontaneously volunteered to don fatigues and paint their own quarters. The project was undertaken, and with such assistance as the engineer could provide, namely paint, brushes, and personal supervision, was carried to a successful and highly satisfactory conclusion. Not only were the young ladies greatly pleased and elated with the resulting improvements in their previously dreary, delapidated surroundings, but the entire hospital also profited by the resulting boost in morale and the discovery that things could be improved in spite of apparent obstacles. Then, too, in view of this kind of interest you can rest assured that the engineer was inclined to find ways and means of getting other things done. He belonged to the hospital now; it was going to be the best hospital in the Army; and he was no longer referred to as the ---- post engineer! Of course, I don't advocate issuing our nurses paint buckets and brushes by any matter of means, but I cite this as an example of an improvement that had long been needed, and had equally as long been declared impossible, but was finally accomplished as a result of the initiative of the chief nurse after becoming aware of the facts involved in a problem far removed from her normal duties.....

..... Again, permit me to cite an example wherein the seemingly impossible was accomplished, this time, through the medium of command support. A certain ZI installation was badly in need of additional commissary facilities. A survey indicated the availability of a heated warehouse which would lend itself admirably to conversion into a super market; however, such conversion involved a little matter of some \$8,000 which was not available. Further study revealed that this amount might be saved in a one month period through the carefully controlled use of electricity for lighting purposes during the hours of darkness. Accordingly, a comprehensive and effective plan was put in effect to include the doubling of the interior guard (as part of a training program) so as to permit the extinguishing of approximately 70% of the street lights, and the continuous patrolling of barracks and quarters' areas so as to insure the strict compliance with orders directing the conservation of electricity. The plan, thus accorded command support, was successful, and the desired commissary became an accomplished fact. Of course, this particular incident no doubt appears far removed from the maintenance and repair problems of a hospital, but it is indicative of what can be accomplished through effective command support. Less spectacular than the above incident, but of even more importance to the day-to-day maintenance program are the careless, negligent, and destructive acts of individuals that require disciplinary control beyond the means of the post engineer.....

..... To improve the present repairs and utilities activities at hospitals the surgeon in command thereof should:

1. Consider his post engineer or maintenance officer as a member of his staff, known to the other staff members, and having his confidence and support.
2. Become familiar with the repairs and utilities situation particularly as regards the resources, capabilities, limitations and problems involved.

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3. Insure the establishment of a sound organization with a clearly defined chain of command.
4. Give effective command support when and where needed.
5. Implement a Preventive Maintenance Program and keep it intact.
6. Develop an over-all repairs and utilities plan within the capabilities of existing resources.

These suggestions are simple, basic fundamentals; they are within the realm of possibility and are not technical in nature; they will insure the maximum benefit from the available means; and they can result in a vast improvement in the present condition of hospital facilities. I have offered them on the assumption that you are interested not only in the condition of your hospitals but also in doing something to improve these conditions, in spite of the lack of resources. Please consider them in this light.

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THE ROLE OF AIR EVACUATION IN MILITARY MEDICINE

Capt R. D. Wilson, MC, Surgeon

1503d Air Transport Wing PACD, MATS, Haneda Air Base



MATS is a combination of the former Air Transport Command and Naval Air Transport Command and Naval Air Transport Service; it is charged with the Air Transportation of essential cargo, mail and personnel, including the evacuation of the sick and wounded for the entire National Military Establishment. MATS was born in June 1948 under the then and now Commanding General, Maj. Gen. Kuter; the Air Surgeon of MATS is Colonel Wilford F. Hall.

Now let me speak of some of the internal mechanics of air-evacuation. There are three main divisions of MATS Air-Evacuation.....

c. Pacific Division - Flights originate from Manila, Okinawa and Tokyo, landing at Guam, Kwajalein, Johnston (as necessary), Hickam (Tripler General Hospital) and thence to Fairfield, Suisun Air Force Base, California. Patients are redeployed from here and as far as possible are flown to military and veterans hospitals of their choice within a radius of three hundred miles of their home. This practice, however, is limited by the bed capacity of the hospitals or by the necessity for sending them to hospitals specializing in certain types of treatment.

MATERIAL: The successful accomplishment of the air evacuation mission requires the complete coordination between the Army, Navy and Air Force, traffic department, operations department, the plane crews, flight nurses and aeromedical technicians, flight surgeon, and the hospital involved.

Each of the three divisions of MATS, i.e., Atlantic, Continental and Pacific, has a Medical Air Evacuation Squadron. This squadron is made up of the flight nurses, aeromedical technicians, and several Medical Service Corps officers, one of whom is the Commanding Officer of the squadron. (The Flight Surgeon usually is assigned separately as the Base Surgeon at the hospital.) All of these people are graduates of specialized training schools at Randolph Field, Texas, or Pensacola, Florida, if they are Navy. The flight nurse's course is about 13 weeks long and the flight surgeon's course is about nine months duration.

Since a flight surgeon does not routinely go along on every flight, the flight nurse is generally the senior medical attendant and it follows that she must rely on her own judgment in an emergency situation. She has been taught that the hospital plane is an airborne ward and that any nursing procedure can be carried out in flight as well as on the ground. She may give medications from her medical kit at her discretion. Mental stability is paramount, for the flight nurse must maintain a wholesome mental attitude toward her work, which by nature is more dangerous than service on the ground. She is subject to flying fatigue, the result of strain due to such factors as air turbulence, hypoxia, physical fatigue and heavy responsibility. Following her graduation from Flight Nurses School, her education continues for three months on-the-job training with MATS under the supervision of a flight nurse; then she is entitled to wear a pair of wings.

The aeromedical technicians serve on the ground and in the air under the supervision of the flight nurse or flight surgeon. They assist in the preparation of records and loading and care of patients. Ordinarily there is one flight nurse and two medical technicians on each flight, for a maximum of 12 hours at a time.

The planes currently in use overseas are the C-54 four engine transports, commonly used by MATS.

During air-evacuation runs they are fitted with tiers of litters, three or four deep, four tiers on the starboard and three tiers on the portside. We are currently transporting 28 patients per trip, departing Wednesday and Friday mornings for Guam, and points east. The total flying time from here to California via this route is about 40 hours. The total time, including landings for refueling and a couple of days stopover at Tripler General Hospital, to the States is 5-6 days. These planes travel approximately 10 times faster than a hospital ship, require only about 1/10 as many patients to make a load and may be directed in any direction over land and water. Trip frequency is greatly increased, eliminating the need for large holding facilities and long delays in getting patients to treatment centers. Plane evacuation affords more comfort than any other type of transportation over long distances. The morale of combat men or those ill at overseas stations is elevated by the knowledge that within a few hours they can be evacuated to treatment centers.

The flight surgeon, or in his absence another medical officer, at the point of origin of the patients is responsible for the careful screening of all patients selected, to determine whether they are suitable for air evacuation. So, we ordinarily see each patient selected for evacuation, determine what treatment is to be carried out in flight and so instruct the flight nurse. Certain patients are normally not acceptable for air evacuation. These include moribund patients or in such poor physical condition that their successful evacuation is doubtful; certain quarantinable diseases (such as small-pox, typhus, cholera, plague, yellow fever); patients in shock; coronary occlusion or CVA within 60 days; severe anemia; respiratory diseases such as severe asthma, far advanced TBC. Certain other patients require special consideration such as psychotics, skull fractures, asthma, patients not desiring air evacuation.

All patients are provided with litters and air mattresses regardless of classification. Patients are classified into six categories:

CATEGORIES: Class 1A - Severe mental; requires sedation and restraints
 Class 1B - Security mental; sedation required, restraints usually required
 Class 1C - Open ward mentals
 Class II - Hospital litter patients
 Class III - Hospital ambulant patients
 Class IV - Troop class; require no medication and can care for selves

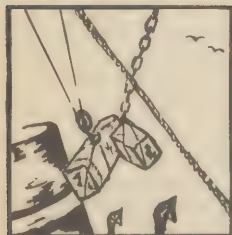
No more than 5 locked ward mental cases can be carried on one flight.

Today air evacuation has become the method of choice in the removal of patients to treatment centers. It has been ranked as one of the 5 greatest life saving measures of military medicine.

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U. S. NAVAL MEDICAL FACILITIES, PHILIPPINES

Lt(jg) L. D. Nelson, MC (USNR), Staff Medical Officer
 Commander, U. S. Naval Forces Philippines



The naval medical facilities ashore in the Philippine Islands consist of two dispensaries located at Subic Bay and Sangley Point, respectively, which are two naval stations located about 65 nautical miles apart, separated by the mountain range of Bataan Peninsula, on the island of Luzon. The naval station at Subic Bay is utilized primarily for ships repair and drydocking of vessels and the naval station at Sangley Point for communication and logistic report to regional fleet and air activities and to Commander U. S. Naval Forces Philippines. The command of Commander U. S. Naval Forces Philippines has no separate medical facilities but must rely on the naval station concurrently occupying the same reservation for treatment and hospitalization of Staff personnel.

These two dispensaries plus one first aid unit at a remote transmitter station must serve approximately 2,215 officers and men comprising the command of COMNAVPHIL. In addition thereto, visiting ships and tenant activities of the U. S. Coast Guard and Fleet Air activities must depend on the medical facilities of COMNAVPHIL. The brunt of this support is borne by the U. S. Naval Station, Sangley Point, Cavite, P. I.

The medical facilities of each station centers about a 25-bed dispensary constructed of temporary quonset materials. However, within the next three months, the dispensary at Sangley Point is to move to permanent quarters reconstructed from the war-torn ruins of the Navy's prewar Canacao hospital's nurses' quarters. This will provide a modernized 25-bed clinic adequately equipped with medical materials to meet the needs of a foreign-shore dispensary. The Bureau of Naval Personnel has recently increased the medical officer allowance to two in order to provide more complete in-patient service locally and decrease the

transfer of patients out of the area.

The dispensary at Subic Bay is staffed by two medical officer, two nurses and 16 hospital corpsmen to supply the medical support of the station census of 1,300, which includes officers, enlisted men and their dependents. Also under the cognizance of the Senior Medical Officer at Subic Bay is the civilian hospital located in the barrio of Olongapo which is on the naval reservation. This hospital has about a 50-bed capacity and is staffed with civilian Filipino doctors.

At Sangley Point, which is a peninsula jutting out into Manila Bay about 5 miles by water from the city of Manila, approximately 1,500 Navy personnel and dependents are quartered thereon. The dispensary serving this population is staffed with one medical officer, three navy nurses, one medical service corps officer and 16 hospital corpsmen.

Sangley Point's dispensary, besides caring for the naval station personnel, also serves the needs of COMNAVPHIL's staff, Fleet Aircraft Service Squadrons and Patrol Squadrons VR-21 and VP-47 of naval air activities.

Besides being responsible for active duty personnel on their respective stations, both dispensaries treat Filipino U. S. Navy retired men and their dependents - estimated at well over 5,000 people in the Manila-Sangley area alone.

A further burden to the workload is obtained through the frequent arrival of Navy ships in the two bays which have inadequate facilities aboard to treat any but minor injuries or illness.....

III. Recent Department of the Army and FEC Publications



AR 15-380, 21 Mar 50 - Boards, Commissions and Committees: MD Board

AR 40-535, 28 Mar 50 - Air Transportation of Patients

GO 8, 15 Mar 50 - Sec II Recommended Lists for Promotion to Col - MD, JAG and Chaplains Corps

SR 110-1-1, Jan 50 - Index of Army Motion Pictures and Film Strips - Medical, par 22

SR 140-155-1, 17 Feb 50 - ORC: Commissioned Officers, Promotion

SR 615-125-1, 6 Mar 50 - Enlistment & Assignment of Partially Disabled Combat-Wounded Veterans - W.W. II

SR 135-425-5, 13 Mar 50 - Civilian Components. Droppage of Non-expendable Orgn Equipment, MD, par 4

SR 40-590-45, 24 Mar 50, C-2 - MD: Admission to and Treatment in Medical Facilities, DA, of Active, Reserve and Retired Personnel of Navy and Marine Corps

RT 8-317-22, 1 Feb 50 - Medical Ambulance Co. (Separate)(National Guard)

TM 8-241, Mar 50 - Military Psychiatric Social Work. Supersedes TB MED 154. 4 Dec 46

T/O&E 8-37, 1 Apr 50 - Medical Co., Infantry Regiment, Airborne

GHQ FEC CIR 12, 17 Mar 50 - Field Ration

PART II

TECHNICAL

SUBJECT	SECTION	PAGE
Japanese B Encephalitis.	IV	13
Scrub Typhus - Report of Two Cases Treated with Aureomycin	V	15
Nursing Care of Scrub Typhus	VI	16
The Control of Scrub Typhus in Japan	VII	17

IV. Japanese B Encephalitis



Japanese B encephalitis has been a continuing problem for American forces in Japan and Okinawa since the occupation of these areas. The disease was also experienced on Guam in 1947 and 1948 when there were approximately 40 Guamanians and 7 American personnel affected. In Japan there were 29 cases with 4 deaths among occupation personnel in 1948 and 10 cases and 2 deaths in 1949. American personnel in Okinawa during these two

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years experienced 2 cases with 1 death in 1948 and 3 cases with 1 death in 1949.

There is now good evidence that Japanese B encephalitis is transmitted by mosquitoes. Based on present knowledge three species of the genus *Culex* (*C tritaeniorhynchus*, *C pipiens* and *C quinquefasciatus*) appear to be the most important vectors. However, it is entirely possible that other species of mosquitoes may also serve as vectors of this disease. Mosquito control then is the most important procedure for the prevention of Japanese B encephalitis. This control can only be effected through rigid application of area, unit and individual procedures, including the elimination of breeding areas where feasible, larviciding, adult mosquito control, screening, use of bed nets and protective clothing and repellents. The pertinent provisions of GHQ, FEC Circular No 39, 9 October 1948, are applicable to this program. It is to be stressed that vaccination is not a substitute for mosquito control in the prevention of Japanese B encephalitis.

The protective value of Japanese B encephalitis vaccine has not been definitely determined; however, the available evidence indicates that the vaccine does offer some protection and its use for occupation personnel is considered desirable. Accordingly, in addition to mosquito control, vaccination is to be accomplished as an additional preventive measure.

The following personnel in Japan and Okinawa will be immunized during the time and periods indicated below:

- a. All military personnel of Army, Navy and Air Force
- b. United States civilian employees
- c. Dependents of above persons on a voluntary basis
- d. British Forces, employees and dependents on a voluntary basis

In MARBO the following personnel will be immunized:

- a. All military personnel of the Army and Air Force
- b. Department of the Army and Air Force civilian employees
- c. Dependents of above personnel on a voluntary basis

Vaccinations on Okinawa are to begin not later than 1 May 1950. In Japan, south of and including Osaka and Kyoto, on or about 15 May 1950, and in the remainder of Japan, on or about 1 June 1950. In MARBO the program is to begin about 1 October 1950.

The quantity of vaccine being made available by the Department of the Army though definitely limited should be adequate for the indicated needs if proper care in conservation procedures are practiced. Of particular importance is the maintenance of the proper storage and distribution temperature of 5 degrees Centigrade, (41 degrees F.). The vaccine is furnished in dry form. Instructions for rehydration furnished in the package should be carefully followed, remembering that the rehydrated material is particularly unstable, should be kept in the refrigerator when not in actual use and that all unused portions of an ampule are to be discarded at the end of the day. Each ampule contains sufficient material for 20 doses and the scheduling of groups for vaccination and preparation of vaccine for use should be planned accordingly.

The rehydrated vaccine is administered for original immunization in 3 doses of one (1) cc each, injected subcutaneously. The second dose is given one week after the first and the third, one month after the first. Persons receiving two or more doses of Japanese B vaccine previously should be given one dose of one (1) cc only, administered at the time other personnel in the area are receiving their third or final dose. Children less than six months of age are not to be given the vaccine and those between six months and one year should receive one-half of the adult dose at the discretion of the medical officer performing the immunization. Japanese B vaccine is to be administered in the Far East Command only; hence individuals from the ZI will not have been vaccinated prior to arrival. Those arriving in Okinawa after 1 June and in Japan after 15 June will receive full course of three doses of the vaccine at intervals of two to four days between doses. Immunizations are not to be administered in the above two commands subsequent to 15 September. Personnel arriving in MARBO between 15 October and 15 December are to receive a full course of three doses as prescribed above for Okinawa and Japan. Vaccinations after 15 December are not contemplated for MARBO. Persons departing Okinawa prior to 1 June; Japan prior to 1 July, and MARBO prior to 1 December 1950 are not to be immunized. Transients, including crews of ships and aircraft are not to be vaccinated.

Since Japanese B vaccine is prepared by cultivation of the virus in eggs and contains a certain amount of egg and chicken protein, it should not be administered to those with a history of sensitivity to egg or chicken. Each person to be vaccinated should be asked the question, "do you eat egg and chicken?". If the answer is "no", the presence or absence of sensitivity should be determined by further questioning. If a state of sensitivity is considered to be present, a statement to that effect should be entered on the immunization register and the vaccine not administered. No skin tests with the vaccine

for desensitization procedures should be attempted.

It is very important that proper records of vaccination be made on both the individual and record copy of the immunization register (WD AGO Form 8-117). AR 40-215 should be referred to for instructions in the entry of records and maintenance of the immunization register. The lot number of vaccine used should be entered on each immunization register.

V. Scrub Typhus - Report of Two Cases Treated with Aureomycin - Captain Eugene M. Marks, MC, Chief of Medical Service, 35th Station Hospital, APO 301



Two cases of scrub typhus were seen during the fall of 1949 at the 35th Station Hospital. Both patients were young white infantry riflemen from the 35th Infantry Regiment. They were members not only of the same platoon but of the same squad, having slept with 4 others in the same squad tent while the regiment was on maneuvers in the Fuji Maneuver Area near Gotemba.

The first case, a 17 year old soldier was admitted on the evening of 2 November 1949 with the chief complaints of fever and generalized skin rash. For about one week prior to admission the patient noted intermittent headache and mild fever both temporarily relieved by aspirin. One day before admission, just a few hours before his outfit left the maneuver area to return to their permanent station, he noted a rash over his chest and abdomen which soon spread over his entire body except for face and neck.

On questioning he related that he had noted "knots" in the left side of his neck for about two weeks prior to admission and that there had been mild chilly sensations with the onset of the fever. There was mild burning of the eyes at the time of admission, moderately severe, diffuse, lower back pain and mild sore throat present for two days prior to admission.

Physical examination revealed an acutely ill, rather listless young male. Temperature was 101.4 degrees, pulse was 88. There was a maculopapular, blotchy, confluent rash over trunk, extremities and genitalia, looking much like a measles rash. The eyes showed a mild peripheral conjunctivitis. There was a mild injection of the anterior tonsillar pillars. The abdomen showed mild right upper quadrant tenderness but the liver was not palpable. Lymph nodes pea to grape size were palpable in anterior cervical, posterior auricular, supraclavicular, axillary, epitrochlear and inguinal areas. The nodes were firm, discrete and slightly tender. Reflexia were not remarkable except for a slight hypo-activity of the knee and ankle jerks. There was no sign of an eschar but the patient had several small calluses on his ankles from his combat boots. One of these, on the left ankle appeared slightly erythematous but was otherwise similar to the others.

Laboratory work on admission was as follows: RBC 4.75 million, WBC 9,400, Differential: 75 neutrophils, 16 lymphocytes, 9 stab cells. Urine showed a trace of albumen, 12-14 RBC and 20-25 WBC per high power field. Throat culture showed predominately pneumococcus. Corrected erythrocyte sedimentation rate was 22 mm per hour.

In the first few days following admission, without treatment, the patient improved symptomatically. Headache and back pain disappeared, patient became considerably more alert and less lethargic. The "callus" on the left ankle developed into a definite eschar passing through a soft pustular stage which broke and produced the typical appearance. Temperature ranged from 99.8 to 104.4 degrees making wide swings and ranging gradually higher in spite of the patient's statement that he felt better. The skin rash gradually faded, disappearing by the sixth day of hospitalization. The white blood count continued within normal limits and the neutrophilia persisted.

On 5 November 1949, although laboratory confirmation of the diagnosis had not been obtained the patient was started on oral aureomycin therapy. An initial dose of 750 mgm was given broken into 3 separate hourly doses of 250 mgm. Maintenance dose was 250 mgm every four hours. Temperature when treatment was started was 102 degrees. Within eleven hours after the first 250 mgm was given temperature dropped to 98 degrees and remained within normal limits thereafter except for one brief swing to 99.4 degrees in the first 24 hours of therapy. Treatment was continued until a total of 5-3/4 grams of aureomycin had been given. There were no side reactions to the drug.

Convalescence was uneventful. The lymphadenopathy gradually subsided and the sed rate and differential blood count returned to normal. Patient was discharged from the hospital on 2 December '49.

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Agglutination titers for Proteus antigens OXK and OX19, results which were obtained from the 406th Medical General Laboratory after therapy was begun, are given in the table.

ANTIGEN	4 Nov	12 Nov	16 Nov	1 Dec	9 Dec
OXK	1:40	1:40	1:80	1:160	1:20
OX19	1:80	No titer	No titer	1:40	No titer

The second case, a 19 year old soldier, was admitted on the afternoon of 3 November 1949, about 18 hours after the first case. About 2 days prior to admission the patient developed severe shaking chills. These persisted intermittently until admission. There was mild midback pain, dull in nature, which started with the onset of the first chill. Appetite was good and the patient felt quite well between chills. There was mild unproductive cough for 2 to 3 days prior to admission. There was a history of chills and fever on two occasions while patient was stationed in Korea in early 1949. Malaria was suspected and patient was treated for malaria but diagnosis was never confirmed.

Physical examination revealed a young white male not appearing acutely ill. Temperature was 100.8 degrees, pulse 96. There was a very slight peripheral conjunctivitis, and there was bean-sized bilateral inguinal lymphadenopathy, firm, nontender and discrete. Remainder of physical examination was not remarkable except for psoriasis of the scalp and over the anterior lower legs.

Initial laboratory work was as follows: RBC 4.28 million, WBC 4,100, Differential: 46 neutrophils, 30 lymphocytes, 20 stab cells, 4 juveniles. Urine was essentially negative.

During the first days following admission temperature ranged from 98.4 to 102.4 degrees with wide swings. The patient's back pain eased but the chills persisted. Repeated blood smears for malaria parasites were negative.

On 5 November 1949 the patient discovered a discrete, maculopapular rash over the arms, legs and trunk which had apparently developed during the night. The rash was less severe than that in the first case and the lesions, as mentioned, were discrete rather than confluent and were more uniform in size, being typical of the rash usually pictured in scrub typhus. At that time also generalized, firm, discrete nontender lymphadenopathy was noted. There was no evidence of an eschar.

The patient was started on aureomycin therapy at the same time and with the same dosage scheduled as the first case. At the start of treatment the temperature was 102 degrees. In 11 hours temperature dropped to 98.6 degrees and remained within normal limits thereafter. A total of 5-3/4 grams of aureomycin was given. There were no side reactions to the drug. The skin rash faded rapidly and was completely gone on 8 November 1949. The lymphadenopathy gradually subsided. Convalescence was uneventful. Patient was discharged on 2 December '49.

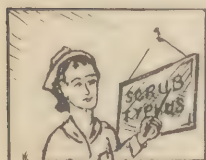
Agglutination titers for Proteus antigens are given in the table:

ANTIGEN	5 Nov	7 Nov	12 Nov	16 Nov	9 Dec
OXK	No titer	No titer	1:40	1:40	1:80
OX19	1:20	1:40	1:40	1:40	1:80

Serial specimens of serum were obtained to demonstrate the appearance and rise of OXK agglutins. Although these specimens were not run simultaneously, a rise in the agglutins was observed and supported the fact that the clinical picture was consistent with the disease. The non-specific appearance of OX19 agglutins may be accounted for by previous antigenic stimuli with typhus vaccine.

Aureomycin was used in the treatment of these cases because it was readily available and chloromycetin was less readily so. Response was excellent.

VI. Nursing Care of Scrub Typhus - Lt. Margaret M. Murphy, ANC, 35th Station Hospital, APO 301



In this disease we have a patient whose illness, after an incubation period of 6 - 18 days, begins suddenly with fever, chills, and headache. At the onset a primary lesion, the eschar, may be found at the site of attachment of an infected mite.

During the first week the fever increases progressively, generally reaching 104 - 105, and the patient usually complains of severe headache. A fine macular rash is

present over entire body. In the second week, the temperature remains elevated, the pulse rate increases and there is a drop in the systolic blood pressure. Certain patients develop frank signs of involvement of the central nervous system, for example delirium, stupor and muscular twitching; others develop signs of pneumonia or circulatory failure. Toward the end of the second week, the temperature of those destined to recover falls by lysis over a period of several days. Death when it occurs happens about the end of the second week and is frequently the result of secondary bacterial pneumonia, encephalitis or circulatory failure.

Skillful and diligent nursing is of great importance. Constant supervision is necessary to prevent a delirious patient from doing himself bodily harm. Stuporous patient or those in coma should be moved from side to side to avoid bed sores. A rise of body temperature to 104 should be treated promptly by cold sponges. Oral hygiene must be carefully attended to. Fluids must be administered at frequent intervals and a liquid or semi-solid diet high in caloric content and vitamins is desirable. The physician generally prescribes paraldehyde or chloral hydrate for the control of delirium and restlessness. Barbiturates are generally avoided since many patients suffering from typhus react unfavorably to them. Oxygen therapy for individuals with pulmonary complications is advisable. Neither penicillin nor the sulfonamides are useful in this disease unless secondary bacterial infection occurs. Chloromycetin and aureomycin, two recently discovered drugs, are highly effective therapeutic agents in the treatment of scrub typhus.

A patient who has recovered from scrub typhus should not return to duty for at least a month after becoming afebrile, and more severe cases demand even longer periods of convalescence.

There is no evidence of communicability of scrub typhus from man to man, therefore isolation of patients and quarantine are not indicated in this disease.

REFERENCE: "Viral & Rickettsial Infections of Man", Thomas M. Rivers, M.D.

VII. The Control of Scrub Typhus in Japan - Capt H. C. Barnett, MSC, 406th Med Gen Lab, APO 500



I. Introduction: The occurrence of 24 cases of scrub typhus in Army personnel during 1948 focused sharp attention on this medical problem in Japan, particularly since these cases were reported from an area which had never previously been reported as endemic for the disease. Surveys conducted during 1949 in the Fuji Maneuver Area, where the cases occurred during 1948, failed to indicate a heavy chigger population, nor did there appear to be any significant number of chigger infestations in troops on maneuvers. However, it must be emphasized that surveys conducted over such an extensive area may easily overlook localized "hot spots" where the chigger population is heavy.

Surveys during 1948 and 1949 in this area failed to reveal Trombicula akamushi, long known as the vector of scrub typhus in Japan; however, the following species of Trombicula have been taken: T. scutellaris, T. japonica, T. fuji, T. intermedia, T. palpalis, T. pallida, and Ganrliepia sp.

Considering the occurrence of an epidemic in a previously unreported area and the paucity of data on chigger distribution, it is important that unit commanders as well as medical personnel recognize the necessity of actively carrying out preventive measures against the disease. Prevention of scrub typhus can be undertaken from two approaches: By terrain disinfection and by personal protective measures.

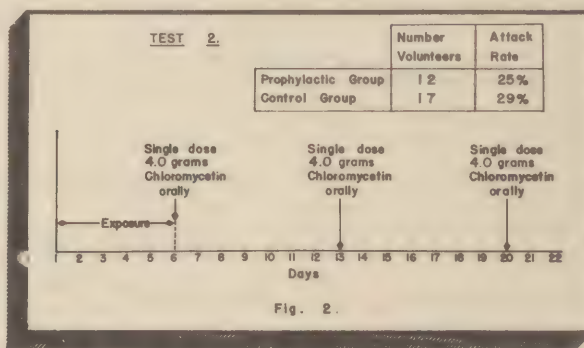
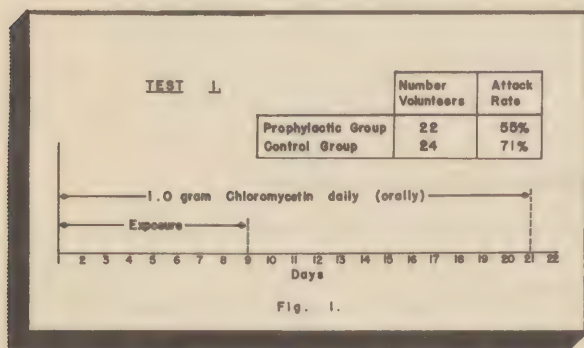
II. Terrain Disinfection: Terrain disinfection has obvious advantages from the standpoint of control since it seeks to eradicate the chigger vector which also serves as one of the reservoirs for the rickettsiae. Area control of chiggers can be effected in two ways: By clearing and burning vegetation and brush, and by the application of miticides to infested areas. Brush clearing and burning proved to be a very useful control method during World War II, particularly in the southwest Pacific area, where "kunai" grass occurred. However, both brush clearing and miticide application are limited in practicality to small areas such as camp or bivouac sites and cannot be readily applied to extensive areas unless required by military exigencies. The control of rodents, which also serve as reservoirs for the disease, has never proven practical when large areas of terrain are involved.

The Orlando, Florida laboratory of the Bureau of Entomology and Plant Quarantine, U. S. Department of Agriculture, has conducted extensive tests of materials which might serve as useful miticides. A recent report from this institution (1) described results from 75 compounds tested. Crude benzene hexachloride was found to be the most effective of the materials tested, using 25 pounds of toxicants per acre, against American species of chiggers. Valone (2-iso-valeryl-1, 3-indandione) and pentachlorophenol

also provided essentially complete control when applied at a dosage equivalent to 25 lbs. of pure material per acre. Sulphur and DDT were considerably less effective than several of the compounds tested. In field tests conducted by Traub and Frick (2) in Malaya in 1948 on *Trombicula akamushi* and *T. deliensis* it was found that, three days after application of chlordane and toxaphene (chlorinated camphene) to field plots at the rate of three lbs. per acre, less than 10% of the chigger mites survived, while with Compound 118 (Julius Hyman and Company) less than 5% of the chigger mites survived. During this time untreated check plots showed a 100% increase in the chigger population. Unfortunately drought conditions in the experimental area caused a great reduction in the chigger population one week after the experiments commenced, so that more extensive data could not be obtained.

At this date area control of chiggers by use of miticides is still in the experimental stage, and final evaluation of these materials, none of which are presently standard issue items, still remains to be accomplished.

III. Personal Protective Measures: The methods to be considered are chemo-prophylaxis, vaccination and impregnation of clothing with miticidal or repellent materials. Recent work in Malaya (3) with chloromycetin as a prophylactic has given only limited promise. Two field tests were conducted, exposing a total of 75 human volunteers to hyperendemic areas. The experimental procedures and results are illustrated in the following Figs. 1 and 2. In the control groups in both tests, the clinical disease began



Figures modified after
Smadel, Traub et al (3).

to appear on the 12th day after initial exposure, with the maximal number of cases occurring on the 15th day. In the prophylactic groups, the clinical evidence of disease did not appear until five days after the drug was discontinued. Thus, chloromycetin seems to have a suppressive effect against scrub typhus. In many respects similar to that of atabrine against benign tertian malaria. It is of interest to note that the clinical course of the disease in the prophylactic groups and control groups did not differ except for the absence of eschar formation in the prophylactic groups. Relapses were common to both the prophylactic and control groups; 54% of the 37 volunteers who contracted the disease suffered from one or more relapses. There was no evidence of toxic manifestation or sensitization in the volunteers receiving chemo-prophylaxis.

Several attempts have been made to produce a satisfactory vaccine against scrub typhus, but none have been very successful. Both American and British vaccines have been tested on humans in hyperendemic areas, particularly in Southeast Asia, but in numerous instances cases have occurred in vaccinated persons. Difficulties arising in the production of an efficient vaccine stem in part from the fact that antigenic differences exist among strains of *Rickettsia tsutsugamushi* and no broadly antigenic strains have been found.

The third measure applicable to personal protection is the use of miticides or repellents as clothing impregnants. Maj. R. N. McCulloch of the Australian Army (unpublished) developed a "stopping time" method of testing materials as miticides in clothing. A material was considered to be miticidal if it stopped chiggers in 15 minutes or less. As a result of his tests, the Australian Army adopted dibutyl phthalate as a clothing impregnant. Following this work, the U. S. Army Typhus Commission seeking materials readily available in overseas areas, developed a similar process utilizing the standard issue insect repellent, dimethyl phthalate, and ordinary laundry soap as an emulsifying agent. Subsequently Snyder and Morton (4) of the Orlando Laboratory found that benzyl benzoate possessed similar miticidal properties and that after one laundering of impregnated cloth no miticidal activity was lost. However,

additional launderings resulted in progressive loss of miticidal activity. Following this work a combination dibutyl phthalate-benzyl benzoate-commercial emulsifier concentrate was adopted by the U.S. Army as the standard issue clothing impregnate against chiggers. More recently King (5) has reported 5 compounds (benzil, cresyl benzoate, 2-thenyl benzoate, diphenyl carbonate, and 2-thenyl salicylate) which remain effective through 7 to 10 launderings when tested against the American chigger, Ascariscus masoni. The residual effectiveness of impregnates in clothing is based on the following laundering technique. Clothing is washed for 10 minutes in 120 degrees F. water containing 0.7% soap in an electric washing machine and rinsed twice for 5 minutes in cool water.

It is entirely possible that at sometime in the foreseeable future the standard issue clothing impregnate will be changed, but this in no way detracts from the fact that the present issue material affords almost complete protection when used properly and when impregnated with the required frequency. Inspection of units in the field has revealed that while all units are using clothing impregnation, considerable variation occurs in materials used, method of impregnation and frequency of impregnation.

IV. Control Procedures Presently Applicable in Japan: Attention is invited to TB MED 31, Scrub Typhus Fever, Jan. 48, and to Cir. No. 14, Headquarters Eighth Army, dated 20 Feb 50. Medical personnel and unit commanders concerned with the control of scrub typhus should be cognizant of the following points of information:

1. Camp sites and bivouac areas should be cleared of weeds, grasses and underbrush prior to arrival of troops, preferably by native laborers. Vegetation should be cut, burned or hauled away. A bivouac area is defined as an area of ground where troops sleep for at least one night.

2. The material to be used in clothing impregnation is QM issue stock No. 51-R-300-40, Anti-mite fluid (45% benzyl-benzoate, 45% dibutyl phthalate, 10% emulsifier). An emulsion for treating 50 uniforms can be prepared by mixing slowly 1 gallon of this concentrate with 17 gallons of water. Substitute items for this anti-mite concentrate are QM issue stock No. 51-R-300-20, Anti-mite fluid (90% dibutyl phthalate, 10% emulsifier), and No. 51-R-300-30, Anti-mite fluid (90% dimethyl phthalate, 10% emulsifier). The method of preparation of an emulsion with all of these concentrates is identical.

3. In maneuver areas clothing should be reimpregnated after every laundering, particularly if hot water or machine laundering has been utilized.

4. Uniform and socks should be impregnated. Blankets should also be impregnated where troops are required to sleep on the ground. Underclothing should never be impregnated. After impregnation of a uniform or blanket, it should be marked indicating date of treatment.

5. Attention is invited to Sec III, Weekly Directive No. 56, Headquarters Eighth Army, dated 1 Oct 49, authorizing issue of a third suit of herringbone twills to enlisted men habitually wearing herringbone twills.

6. Airplane spraying or dusting of camp sites and clearing vegetation by the use of flame throwers is prohibited by Cir. 14, Headquarters Eighth Army, 1950. This circular also prescribes that scrub typhus control measures be carried out during the period 1 May - 1 December.

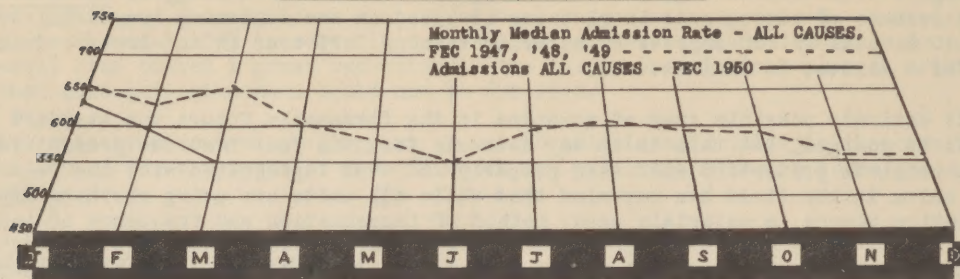
7. Troops on maneuvers in endemic areas should be well oriented on the subject of scrub typhus control. Education of troops and the implementation of control programs are the responsibility of individual unit commanders. Emphasis should be given to the fact that typhus vaccine protects only against epidemic (louse borne) typhus and not against scrub typhus. A valuable educational medium will be found in Miscellaneous Film No. 1247, "Control of Scrub Typhus Fever," running time 28 minutes.

Summary: This paper discusses the control of scrub typhus by terrain disinfection of chiggers, by chemoprophylaxis, by vaccination and by clothing impregnation. Recent work on miticides with several new materials is reviewed, but terrain disinfection by miticides is still considered to be in the experimental stage. A description of recent studies on the use of chloromycetin as a prophylactic is prescribed, indicating that this antibiotic is a suppressive drug, resembling atabrine in its action on benign tertian malaria. The problems involved in clothing impregnation are reviewed. The discussion is closed with a list of recommended control measures presently applicable in Japan.

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2. Traub, R. (Maj. MSC) and Frick, L. (Capt. MSC). "Interim Report on Miticides Tested in Malaya in 1949." Unpublished report to Office of the Surgeon General, Washington, D.C., 1949
3. Smadel, J., Traub, R., et al. "Chloramphenicol (Chloromycetin) in the Chemoprophylaxis of Scrub Typhus (Tsutsugamuchi Disease). II. Results with Volunteers Exposed in Hyperendemic Areas of Scrub Typhus." Amer.J.Hyg. 50(1):75-91. 1949
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5. King, W.V. Amer.J.Trop.Med. 28(3):487-497. 1948

PART III - STATISTICAL

HEALTH OF THE COMMAND



Admission rates per 1000 troops per annum for the five-week period ending 31 March 1950 were as follows:

	FEC	JAPAN	MARBO	PHILCOM (AF)	RYCOM
All Causes	550	596	250	287	520
Diseases	501	548	200	266	453
Injuries	49	48	49	22	66
Psychiatric	8.3	8.9	0	8.7	8.5
Common Respiratory Diseases & Flu	86	101	14	22	55
Primary Atypical Pneumonia	2.7	2.9	1.1	4.3	2.1
Common Diarrhea	2.2	2.2	0	4.3	2.7
Bacillary Dysentery	.21	0	0	2.9	.53
Amebic Dysentery	.27	.09	0	2.9	.53
Malaria, new	.27	.09	0	4.3	0
Infectious Hepatitis	3.6	4.2	1.1	2.9	1.6
Mycotic Dermatoses	1.4	1.8	1.1	0	0
Rheumatic Fever	.55	.63	0	1.4	0
Venereal Diseases	136	141	36	94	169

During the month of March the "all causes" admission rate of 550 presented a decrease from the rate of 595 for the preceding month. The FEC's decline in admissions for all causes for this month is due primarily to the decrease in incidence of venereal, common respiratory diseases and influenza in Japan. The above rate for March compares favorably with the rates for the same month in 1947, 1948 and 1949 which were 966, 618 and 654 respectively. There was no unusual incidence of diseases among military personnel in the Far East Command during the month.

Only once before, December 1949, has the FEC experienced an average daily non-effective rate as low as 16 per 1000 per day. The March rate of 16 is a decrease of 1 from the previous month and is the result of a slight decline in Japan and PHILCOM (AF) rates.

Common Respiratory Diseases and Influenza: The seasonal peak incidence of these infections appears to have been reached in February since the admission rate dropped from 97 in that month to 86 for March. This is in some contrast to the 1949 experience when the March rate was 120, an increase of 30 from February of that year. (It is of some interest that no specific diagnosis of influenza was made in 1949 while influenza B has been demonstrated among troops in several areas in Japan during each of the first 3 months of this year.) The principal decreases in admissions for this group of diseases this month occurred in Japan with a drop in rate to 101 from 117. In Japan, the principal incidence continued to be in the Tokyo-Yokohama area. A notable exception was a rather sharp but limited outbreak at Camp Haugen in northern Honshu with a peak of 572/1000/per annum for the week ending 3 March. By 24 March this rate had decreased to 48.

Malaria: The malaria situation continues excellent and for March only 4 new cases were reported which gave a rate of .27. Three of the above cases occurred in PHILCOM (AF) and 1 in Japan. It is noted that RYCOM has had no new cases in the past two months.

Venereal Diseases: The total venereal diseases rate of 136 for March is the lowest recorded since February 1949, and represents a decrease from 153 for the previous month. The decrease is attributed to Japan which had a decrease from 164 in February to 141 for March and RYCOM which had a decrease from 178 to 169 for the same period. Japan's white troops component which experienced a decrease of 26 in its rate was the chief factor. PHILCOM (AF) and MARBO had increases from 58 in February to 94 in March and 35 in February to 36 in March respectively.

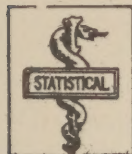
Miscellaneous Diseases: Decreases were noted in the incidence of streptococcal infections (strepto-

coccal sore throat and scarlet fever), enteric infections and infectious hepatitis. In contrast to last month's experience when pneumonia rates fell in the presence of increased incidence of common respiratory diseases and influenza, the incidence of total pneumonia increased slightly in March with a rate of 4.8 to 5.5. The admission rates for atypical pneumonia remaining the same, this increase was entirely due to other types of this disease principally those of bacterial origin.

Non-Battle Injuries and Deaths: The non-battle injury admission rate increased from 43 per 1000 per annum in February to 49 in March. Although this is a considerable increase, the rate is considered good for this type of admission and compares favorably with the average monthly non-battle injury admission rate. Thirty-six deaths were reported among military personnel for the five week period in March; 10 resulting from disease and 26 from injuries. Of the 10 deaths from disease, 4 were reported by PHILCOM (AF).

Evacuation:

Tabulated below are the number of patients evacuated from the major commands to the ZI during the 5-report weeks in Mar and the number of patients awaiting evacuation as of 31 Mar 50:



	BY AIR	BY WATER	TOTAL	PNTS AWAIT EVAC
JAPAN	207	27	234	131
MARBO	4	1	5	0
PHILCOM (AF)	35	3	38	12
RYCOM	46	9	55	25
FEC	292	40	332	168

Evacuations of military personnel per 1000 strength for the period of 25 Feb to 31 Mar were as follows: JAPAN - 1.7; MARBO - .11; PHILCOM - 4.3; RYCOM - 2.6; FEC - 1.8

Hospitalization: The bed status as of 31 March 1950 was as follows:

	Total T/O Beds Auth.	Total T/O Beds Establ.	Total T/O Beds Occupd.	% Auth. T/O Beds Occupd.	% of Establ. Beds Occupd.
JAPAN	4,600	4,226	1,501	33	36
MARBO	200	200	93	47	47
PHILCOM (AF)	1,250	1,250	483	39	39
RYCOM	750	428	227	30	53
FEC	6,800	6,104	2,304	34	38

IN THIS ISSUE

PAGE

Extracts from Talks Presented at 1950 FEC Surgeons' Conference.	1
Information of General Interest to Medical Department Personnel.	Inside Front Cover
Japanese B Encephalitis.	13
Nursing Care of Scrub Typhus	16
Organization of the Medical Section.	1
Recent Department of the Army and FEC Publications	13
Scrub Typhus - Report of Two Cases Treated with Aureomycin . . .	15
Statistical.	20
The Control of Scrub Typhus in Japan	17



The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor